House of Representatives

General Assembly

File No. 738

January Session, 2007

Substitute House Bill No. 7163

House of Representatives, May 3, 2007

The Committee on Judiciary reported through REP. LAWLOR of the 99th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES AND REVISING THE SCOPE OF PODIATRIC MEDICINE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 1-43 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The use of the following form in the creation of a power of attorney is authorized, and, when used, it shall be construed in accordance with the provisions of this chapter:

"Notice: The powers granted by this document are broad and sweeping. They are defined in Connecticut Statutory Short Form Power of Attorney Act, sections 1-42 to 1-56, inclusive, of the general statutes, which expressly permits the use of any other or different form of power of attorney desired by the parties concerned. The grantor of any power of attorney or the attorney-in-fact may make application to a court of probate for an accounting as provided in subsection (b) of

section 45a-175.

Know All Men by These Presents, which are intended to constitute a GENERAL POWER OF ATTORNEY pursuant to Connecticut Statutory Short Form Power of Attorney Act:

That I .... (insert name and address of the principal) do hereby appoint .... (insert name and address of the agent, or each agent, if more than one is designated) my attorney(s)-in-fact TO ACT .....

If more than one agent is designated and the principal wishes each agent alone to be able to exercise the power conferred, insert in this blank the word 'severally'. Failure to make any insertion or the insertion of the word 'jointly' shall require the agents to act jointly.

First: In my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following matters as each of them is defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent:

(Strike out and initial in the opposite box any one or more of the subdivisions as to which the principal does NOT desire to give the agent authority. Such elimination of any one or more of subdivisions (A) to **[**(L)**]** (K), inclusive, shall automatically constitute an elimination also of subdivision **[**(M)**]** (L).)

To strike out any subdivision the principal must draw a line through the text of that subdivision AND write his initials in the box opposite.

(A)	real estate transactions;	( )
(B)	chattel and goods transactions;	( )
(C)	bond, share and commodity transactions;	( )
(D)	banking transactions;	( )
(E)	business operating transactions;	( )
(F)	insurance transactions;	( )

(G)	estate transactions;	( )
(H)	claims and litigation;	( )
(I)	personal relationships and affairs;	( )
(J)	benefits from military service;	( )
(K)	records, reports and statements;	( )
[(L)	health care decisions;	( )**]**
[(M)**]** (L)	all other matters;	( )

……

……

……

……

(Special provisions and limitations may be included in the statutory short form power of attorney only if they conform to the requirements of the Connecticut Statutory Short Form Power of Attorney Act.)

Second: With full and unqualified authority to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact shall select;

Third: Hereby ratifying and confirming all that said attorney(s) or substitute(s) do or cause to be done.

In Witness Whereof I have hereunto signed my name and affixed my seal this .... day of ...., 20...

.... (Signature of Principal) (Seal)

(ACKNOWLEDGMENT)"

The execution of this statutory short form power of attorney shall be duly acknowledged by the principal in the manner prescribed for the acknowledgment of a conveyance of real property.

No provision of this chapter shall be construed to bar the use of any other or different form of power of attorney desired by the parties concerned.

Every statutory short form power of attorney shall contain, in

boldface type or a reasonable equivalent thereof, the "Notice" at the beginning of this section.

(b) A power of attorney is a "statutory short form power of attorney", as this phrase is used in this chapter, when it is in writing, has been duly acknowledged by the principal and contains the exact wording of clause First set forth in subsection (a) of this section, except that any one or more of subdivisions (A) to **[**(M)**]** (K) may be stricken out and initialed by the principal, in which case the subdivisions so stricken out and initialed and also subdivision **[**(M)**]** (L) shall be deemed eliminated. A statutory short form power of attorney may contain modifications or additions of the types described in section 1-56.

(c) If more than one agent is designated by the principal, such agents, in the exercise of the powers conferred, shall act jointly unless the principal specifically provides in such statutory short form power of attorney that they are to act severally.

(d) (1) The principal may indicate that a power of attorney duly acknowledged in accordance with this section shall take effect upon the occurrence of a specified contingency, including a date certain or the occurrence of an event, provided that an agent designated by the principal executes a written affidavit in accordance with section 1-56h that such contingency has occurred.

(2) The principal may indicate the circumstance or date certain upon which the power of attorney shall cease to be effective.

Sec. 2. Section 1-55 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

In a statutory short form power of attorney, the language conferring general authority with respect to all other matters shall be construed to mean that the principal authorizes the agent to act as an alter ego of the principal with respect to any matters and affairs not enumerated in sections 1-44 to 1-54, inclusive, except health care decisions, and which

the principal can do through an agent.

Sec. 3. Subsection (g) of section 17a-238 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(g) The commissioner's oversight and monitoring of the medical care of persons placed or treated under the direction of the commissioner does not include the authority to make treatment decisions, except in limited circumstances in accordance with statutory procedures. In the exercise of such oversight and monitoring responsibilities, the commissioner shall not impede or seek to impede a properly executed medical order to withhold cardiopulmonary resuscitation. For purposes of this subsection, "properly executed medical order to withhold cardiopulmonary resuscitation" means (1) a written order by the attending physician; (2) in consultation and with the consent of the patient or a person authorized by law; (3) when the attending physician is of the opinion that the patient is in a terminal condition, as defined in section 19a-570, which condition will result in death within days or weeks; and (4) when such physician has requested and obtained a second opinion from a Connecticut licensed physician in the appropriate specialty that confirms the patient's terminal condition; and includes the entry of such an order when the attending physician is of the opinion that the patient is in the final stage of a terminal condition but cannot state that the patient may be expected to expire during the next several days or weeks, or, in consultation with a physician qualified to make a neurological diagnosis, deems the patient to be permanently unconscious, provided the commissioner has reviewed the decision with the department's director of community medical services, the family and guardian of the patient and others **[**who**]** whom the commissioner deems appropriate, and determines that the order is a medically acceptable decision.

Sec. 4. Subsection (a) of section 19a-7d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Commissioner of Public Health may establish, within available appropriations, a program to provide three-year grants to community-based providers of primary care services in order to expand access to health care for the uninsured. The grants may be awarded to community-based providers of primary care for (1) funding for direct services, (2) recruitment and retention of primary care clinicians and registered nurses through subsidizing of salaries or through a loan repayment program, and (3) capital expenditures. The community-based providers of primary care under the direct service program shall provide, or arrange access to, primary and preventive services, referrals to specialty services, including rehabilitative and mental health services, inpatient care, prescription drugs, basic diagnostic laboratory services, health education and outreach to alert people to the availability of services. Primary care clinicians and registered nurses participating in the state loan repayment program or receiving subsidies shall provide services to the uninsured based on a sliding fee schedule, provide free care if necessary, accept Medicare assignment and participate as **[**a**]** Medicaid **[**provider**]** providers, or provide nursing services in school-based health centers. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish eligibility criteria, services to be provided by participants, the sliding fee schedule, reporting requirements and the loan repayment program. For the purposes of this section, "primary care clinicians" includes family practice physicians, general practice osteopaths, obstetricians and gynecologists, internal medicine physicians, pediatricians, dentists, certified nurse midwives, advanced practice registered nurses, physician assistants and dental hygienists.

Sec. 5. Subsection (a) of section 19a-17 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) Each board or commission established under chapters 369 to 376, inclusive, 378 to 381, inclusive, and 383 to 388, inclusive, and the Department of Public Health with respect to professions under its

jurisdiction which have no board or commission may take any of the following actions, singly or in combination, based on conduct which occurred prior or subsequent to the issuance of a permit or a license upon finding the existence of good cause:

(1) Revoke a practitioner's license or permit;

(2) Suspend a practitioner's license or permit;

(3) Censure a practitioner or permittee;

(4) Issue a letter of reprimand to a practitioner or permittee;

(5) Place a practitioner or permittee on probationary status and require the practitioner or permittee to:

(A) Report regularly to such board, commission or department upon the matters which are the basis of probation;

(B) Limit practice to those areas prescribed by such board, commission or department;

(C) Continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation;

(6) Assess a civil penalty of up to **[**ten**]** twenty-five thousand dollars; or

(7) Summarily take any action specified in this subsection against a practitioner's license or permit upon receipt of proof that such practitioner has been:

(A) Found guilty or convicted as a result of an act which constitutes a felony under (i) the laws of this state, (ii) federal law or (iii) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state; or

(B) Subject to disciplinary action similar to that specified in this

subsection by a duly authorized professional agency of any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction. The applicable board or commission, or the department shall promptly notify the practitioner or permittee that his license or permit has been summarily acted upon pursuant to this subsection and shall institute formal proceedings for revocation within ninety days after such notification.

Sec. 6. Section 19a-26 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The Department of Public Health may establish, maintain and control state laboratories to perform examinations of supposed morbid tissues, other laboratory tests for the diagnosis and control of preventable diseases, and laboratory work in the field of sanitation, environmental and occupational testing and research studies for the protection and preservation of the public health. Such laboratory services shall be performed upon the application of licensed physicians, other laboratories, licensed dentists, licensed podiatrists, local directors of health, public utilities or state departments or institutions, subject to regulations prescribed by the Commissioner of Public Health, and upon payment of any applicable fee as **[**hereinafter**]** provided in this section. For such purposes the department may provide necessary buildings and apparatus, employ, subject to the provisions of chapter 67, administrative and scientific personnel and assistants and do all things necessary for the conduct of such laboratories. The Commissioner of Public Health **[**shall**]** may establish a schedule of fees**[**, based upon nationally recognized standards and performance measures for analytic work effort for such laboratory services,**]** provided the commissioner **[**(1) shall waive**]** waives the fees for local directors of health and local law enforcement agencies. **[**and (2)**]** If the commissioner establishes a schedule of fees, the commissioner may waive (1) the fees, in full or in part, for others if the commissioner determines that the public health requires a waiver**[**. The commissioner may waive**]** and (2) fees for chlamydia and gonorrhea testing for nonprofit organizations if the organization

provides combination chlamydia and gonorrhea test kits. The commissioner shall also establish a fair handling fee which a client of a state laboratory may charge a person or third party payer for arranging for the services of the laboratory. Such client shall not charge an amount in excess of such handling fee.

Sec. 7. Section 19a-121 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Department of Public Health shall establish a grant program to provide funds to **[**private agencies which provide services to persons suffering from**]** qualifying individuals and organizations, including local health departments, that serve persons infected with and affected by human immunodeficiency virus ("HIV") or acquired immune deficiency syndrome ("AIDS"), **[**and**]** the families of such persons and persons at risk of contracting HIV or AIDS, or both. The grants shall be used for services including, but not limited to, education, counseling and prevention.

(b) Any agency **[**which**]** that receives funds from the department to provide tests for **[**AIDS**]** HIV shall give priority to persons in high risk categories. **[**and shall establish a fee schedule based upon a person's ability to pay for such test.**]**

Sec. 8. Section 19a-121c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The Department of Public Health shall establish a public information program for the distribution of materials, including but not limited to, pamphlets, films and public service announcements, on HIV and AIDS.

Sec. 9. Section 19a-121f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

[(a) Any municipality, hospital, public or independent college or university or individual**]** Any qualifying individual or organization may apply to the Commissioner of Public Health for a grant-in-aid for

a program established for the study or treatment of **[**acquired immune deficiency syndrome. Such grant shall be used (1) to conduct a study of (A) the effectiveness of procedures available for the prevention of AIDS, (B) testing procedures for the detection of the human immunodeficiency virus, (C) the means by which the transmission of AIDS from person to person can be effectively prevented, or (D) how the disease progresses in the victim, (2) for purposes of providing counseling or psychiatric assistance for persons infected by the human immunodeficiency virus and their families, and (3) the future state resources which will be necessary to address the AIDS epidemic in Connecticut**]** HIV or AIDS, or both. Any request for such grant shall be submitted in writing to the commissioner, in the form and manner prescribed by the commissioner.

[(b) The Commissioner of Public Health shall adopt regulations, and may adopt emergency regulations, in accordance with the provisions of chapter 54, which establish all necessary guidelines and procedures for the administration of such grant program.**]**

Sec. 10. Subsection (i) of section 19a-180 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(i) The commissioner shall develop a short form application for primary service area responders seeking to add an emergency vehicle to **[**its**]** their existing **[**fleet**]** fleets pursuant to subsection (h) of this section. The application shall require **[**the**]** an applicant to provide such information as the commissioner deems necessary, including, but not limited to, (1) the applicant's name and address, (2) the primary service area where the additional vehicle is proposed to be used, (3) an explanation as to why the additional vehicle is necessary and its proposed use, (4) proof of insurance, (5) a list of the providers to whom notice was sent pursuant to subsection (h) of this section and proof of such notification, and (6) total call volume, response time and calls passed within the primary service area for the one year period preceding the date of the application.

Sec. 11. Section 19a-322 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The managers of each crematory shall keep books of record, which shall be open at reasonable times for inspection, in which shall be entered the name, age, sex and residence of each person whose body is cremated, together with the authority for such cremation and the disposition of the ashes. The owner or superintendent shall complete the cremation permit required by section 19a-323, retain a copy for record and immediately forward the original permit to the registrar of the town in which the death occurred. The registrar shall keep the cremation permit on file and record it with other vital statistics. When any body is removed from this state for the purpose of cremation, the person having the legal custody and control of such body shall cause a certificate to be procured from the person in charge of the crematory in which such body is incinerated, stating the facts called for in this section, and cause such certificate to be filed for record with the registrar of the town in which the death occurred. Each crematory shall retain on its premises, for not less than three years after final disposition of cremated remains, books of record, copies of cremation permits, cremation authorization documentation and documentation of receipt of cremated remains.

Sec. 12. Subsection (a) of section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

As used in this chapter and sections 17b-261e, 38a-498b and 38a-525b:

(a) "Institution" means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing

services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for the mentally retarded licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for the mentally retarded.

Sec. 13. Subsection (l) of section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(l) "Assisted living services agency" means an **[**institution**]** agency that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable.

Sec. 14. Subdivision (3) of subsection (c) of section 19a-561 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(3) An affidavit signed by the applicant disclosing any matter in which the applicant (A) has been convicted of an offense classified as a felony under section 53a-25 or pleaded nolo contendere to a felony charge, or (B) has been held liable or enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property, **[**;**]** or (C) is subject to a currently effective injunction or restrictive or remedial order of a court of record at the time of application, or (D) within the past five years has had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including, but not limited to, actions affecting the operation of a nursing facility, residential care home or any facility subject to sections 17b-520 to 17b-535, inclusive, or a similar statute in another state or country.

Sec. 15. Subsection (a) of section 19a-562 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) As used in this section and section 19a-562a, as amended by this act, "Alzheimer's special care unit or program" means any nursing facility, residential care home, assisted living facility, adult congregate living facility, adult day care center, hospice or adult foster home that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, and that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer's disease or dementia.

Sec. 16. Subsection (c) of section 19a-562 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(c) Each Alzheimer's special care unit or program shall develop a standard disclosure form for compliance with subsection (b) of this section and shall annually review and verify the accuracy of the information provided by Alzheimer's special care units or programs. Each Alzheimer's special care unit or program shall update any significant **[**changes**]** change to the information reported pursuant to subsection (b) of this section not later than thirty days after such change.

Sec. 17. Section 19a-562a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

Each Alzheimer's special care unit or program shall annually provide Alzheimer's and dementia specific training to all licensed and registered direct care staff who provide direct patient care to residents enrolled in Alzheimer's special care units or programs. Such requirements shall include, but not be limited to, (1) not less than eight hours of dementia-specific training, which shall be completed not later than six months after the date of employment and not less than three

hours of such training annually thereafter, and (2) annual training of not less than two hours in pain recognition and administration of pain management techniques for direct care staff.

Sec. 18. Section 19a-570 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

For purposes of this section **[**,**]** and sections 19a-571 to 19a-580c, inclusive:

(1) "Advance health care directive" or "advance directive" means a writing executed in accordance with the provisions of this chapter, including, but not limited to, a living will, or an appointment of health care representative, or both;

(2) "Appointment of health care representative" means a document executed in accordance with section 19a-575a, as amended by this act, or 19a-577 that appoints a health care representative to make health care decisions for the declarant in the event the declarant becomes incapacitated;

(3) "Attending physician" means the physician selected by, or assigned to, the patient, who has primary responsibility for the treatment and care of the patient;

(4) "Beneficial medical treatment" includes the use of medically appropriate treatment, including surgery, treatment, medication and the utilization of artificial technology to sustain life;

(5) "Health care representative" means the individual appointed by a declarant pursuant to an appointment of health care representative for the purpose of making health care decisions on behalf of the declarant;

(6) "Incapacitated" means being unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and to reach and communicate an informed decision regarding the treatment;

(7) "Life support system" means any medical procedure or intervention which, when applied to an individual, would serve only to postpone the moment of death or maintain the individual in a state of permanent unconsciousness, including, but not limited to, mechanical or electronic devices, including artificial means of providing nutrition or hydration;

(8) "Living will" means a written statement in compliance with section 19a-575a, as amended by this act, containing a declarant's wishes concerning any aspect of his or her health care, including the withholding or withdrawal of life support systems;

(9) "Next of kin" means any member of the following classes of persons, in the order of priority listed: (A) The spouse of the patient; (B) an adult son or daughter of the patient; (C) either parent of the patient; (D) an adult brother or sister of the patient; and (E) a grandparent of the patient;

(10) "Permanently unconscious" means an irreversible condition in which the individual is at no time aware of himself or herself or the environment and shows no behavioral response to the environment and includes permanent coma and persistent vegetative state;

(11) "Terminal condition" means the final stage of an incurable or irreversible medical condition which, without the administration of a life support system, will result in death within a relatively short time period**, [**time,**]** in the opinion of the attending physician.

Sec. 19. Section 19a-575a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) Any person eighteen years of age or older may execute a document that contains health care instructions, the appointment of a health care representative, the designation of a conservator of the person for future incapacity and a document of anatomical gift. Any such document shall be signed and dated by the maker with at least two witnesses and may be in the substantially following form:

THESE ARE MY HEALTH CARE INSTRUCTIONS.

MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE,

THE DESIGNATION OF MY CONSERVATOR OF THE PERSON

FOR MY FUTURE INCAPACITY

AND

MY DOCUMENT OF ANATOMICAL GIFT

To any physician who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. As my physician, you may rely on these health care instructions and any decision made by my health care representative or conservator of my person, if I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care.

I, ..., the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: Artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct

taking of my life, but only that my dying not be unreasonably prolonged.

I appoint .... to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me, including (1) the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law **[**, including, but not limited to,**]** such as for psychosurgery or shock therapy, and (2) the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If .... is unwilling or unable to serve as my health care representative, I appoint .... to be my alternative health care representative.

If a conservator of my person should need to be appointed, I designate .... be appointed my conservator. If .... is unwilling or unable to serve as my conservator, I designate ..... No bond shall be required of either of them in any jurisdiction.

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give: (check one)

…. (1) any needed organs or parts

…. (2) only the following organs or parts ….

to be donated for: (check one)

(1) …. any of the purposes stated in subsection (a) of section 19a-279f of the general statutes

(2) …. these limited purposes ….

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Date …., 20..

…. L.S.

This document was signed in our presence by .... the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

....	….
(Witness)	(Witness)
….	….
(Number and Street)	(Number and Street)
….	….
(City, State and Zip Code)	(City, State and Zip Code)

STATE OF CONNECTICUT }
} ss. ....
COUNTY OF ....

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by

the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this .... day of .... 20...

…. ….

(Witness) (Witness)

Subscribed and sworn to before me this .... day of .... 20..

….

Commissioner of the Superior Court

Notary Public

My commission expires: ….

(Print or type name of all persons signing under all signatures)

(b) Except as provided in section 19a-579b, an appointment of health care representative may only be revoked by the declarant, in writing, and the writing shall be signed by the declarant and two witnesses.

(c) The attending physician or other health care provider shall make the revocation of an appointment of health care representative a part of the declarant's medical record.

(d) In the absence of knowledge of the revocation of an appointment of health care representative, a person who carries out an advance directive pursuant to the provisions of this chapter shall not be subject to civil or criminal liability or discipline for unprofessional conduct for carrying out such advance directive.

(e) The revocation of an appointment of health care representative does not, of itself, revoke the living will of the declarant.

Sec. 20. Section 19a-577 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

Any person eighteen years of age or older may execute a document that may, but need not be, in substantially the following form:

DOCUMENT CONCERNING THE APPOINTMENT
OF HEALTH CARE REPRESENTATIVE

"I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint .... (Name) to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment, my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, **[**including, but not limited to,**]** such as for psychosurgery or shock therapy, and (2) make the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If this person is unwilling or unable to serve as my health care representative, I appoint .... (Name) to be my alternative health care representative."

"This request is made, after careful reflection, while I am of sound mind."

.... (Signature)
.... (Date)

This document was signed in our presence, by the above-named .... (Name) who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed.

.... (Witness)
.... (Address)
.... (Witness)
.... (Address)

Sec. 21. Section 19a-580f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) An advance directive properly executed prior to October 1, 2006, shall have the same legal force and effect as if it had been executed in accordance with the provisions of this chapter.

(b) An appointment of health care agent properly executed prior to October 1, 2006, shall have the same legal force and effect as if it had been executed in accordance with the provisions of this chapter in effect at the time of its execution.

(c) A power of attorney for health care decisions properly executed prior to October 1, 2006, shall have the same power and effect as provided under section 1-55 of the general statutes in effect at the time of its execution.

Sec. 22. Subsection (c) of section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(c) The Commissioner of Public Health shall establish a list of

twenty-four persons who may serve as members of medical hearing panels established pursuant to subsection (g) of this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of twenty-four members appointed by the commissioner, at least eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, at least one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of this state. All vacancies shall be filled by the commissioner. Successors and **[**appointments**]** members appointed to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner. Each medical hearing panel shall consist of three members, one of whom shall be a member of the Connecticut Medical Examining Board, one of whom shall be a physician or physician assistant, as appropriate, and one of whom shall be a public member. The physician and public member may be a member of the board or a member from the list established pursuant to this subsection.

Sec. 23. Subdivision (7) of section 20-12a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from*

passage):

(7) (A) "Supervision" in hospital settings means the exercise by the supervising physician of oversight, control and direction of the services of a physician assistant. Supervision includes but is not limited to: (i) Continuous availability of direct communication either in person or by radio, telephone or telecommunications between the physician assistant and the supervising physician; (ii) active and continuing overview of the physician assistant's activities to ensure that the supervising physician's directions are being implemented and to support the physician assistant in the performance of his or her services; (iii) personal review by the supervising physician of the physician assistant's practice at least weekly or more frequently as necessary to ensure quality patient care; (iv) review of the charts and records of the physician assistant on a regular basis as necessary to ensure quality patient care; (v) delineation of a predetermined plan for emergency situations; and (vi) designation of an alternate licensed physician **[**registered with the department pursuant to section 20-12c**]** in the absence of the supervising physician.

(B) "Supervision" in settings other than hospital settings means the exercise by the supervising physician of oversight, control and direction of the services of a physician assistant. Supervision includes, but is not limited to: (i) Continuous availability of direct communication either in person or by radio, telephone or telecommunications between the physician assistant and the supervising physician; (ii) active and continuing overview of the physician assistant's activities to ensure that the supervising physician's directions are being implemented and to support the physician assistant in the performance of his or her services; (iii) personal review by the supervising physician of the physician assistant's services through a face-to-face meeting with the physician assistant, at least weekly or more frequently as necessary to ensure quality patient care, at a facility or practice location where the physician assistant or supervising physician performs services; (iv) review of the charts and records of the physician assistant on a regular

basis as necessary to ensure quality patient care and written documentation by the supervising physician of such review at the facility or practice location where the physician assistant or supervising physician performs services; (v) delineation of a predetermined plan for emergency situations; and (vi) designation of an alternate licensed physician **[**registered with the department pursuant to section 20-12c**]** in the absence of the supervising physician.

Sec. 24. Subdivision (7) of subsection (a) of section 20-74s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(7) "Supervision" means the regular on-site observation of the functions and activities of an alcohol and drug counselor in the performance of his or her duties and responsibilities to include a review of the records, reports, treatment plans or recommendations **[**developed by a licensed alcohol and drug counselor**]** with respect to an individual or group.

Sec. 25. Subsection (t) of section 20-74s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(t) Nothing in this section shall be construed to apply to the activities and services of a person licensed **[**or certified**]** in this state to practice medicine and surgery, psychology, marital and family therapy, clinical social work, **[**chiropractic, acupuncture, physical therapy, occupational therapy, nursing or any other profession licensed or certified by the state, when**]** professional counseling, advanced practice registered nursing or registered nursing, when such person is acting within the scope of the person's **[**profession or occupation**]** license and doing work of a nature consistent with **[**a**]** that person's **[**training**]** license, provided the person does not hold himself or herself out to the public as possessing a license or certification issued pursuant to this section.

Sec. 26. Subsection (a) of section 20-54 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) No person other than those described in section 20-57 and those to whom a license has been reissued as provided by section 20-59 shall engage in the practice of podiatry in this state until such person has presented to the department satisfactory evidence that such person **[**has had a high school education or its equivalent,**]** has received a diploma or other certificate of graduation from an accredited school or college of chiropody or podiatry approved by the Board of Examiners in Podiatry with the consent of the Commissioner of Public Health, nor shall any person so practice until such person has obtained a license from the Department of Public Health after meeting the requirements of this chapter. A graduate of an approved school of chiropody or podiatry subsequent to July 1, 1947, shall present satisfactory evidence that he or she has been a resident student through not less than four graded courses of not less than thirty-two weeks each in such approved school and has received the degree of D.S.C., Doctor of Surgical Chiropody, or Pod. D., Doctor of Podiatry, or other equivalent degree; and, if a graduate of an approved chiropody or podiatry school subsequent to July 1, 1951, that he or she has completed, before beginning the study of podiatry, a course of study of an academic year of not less than thirty-two weeks' duration in a college or scientific school approved by said board with the consent of the Commissioner of Public Health, which course included the study of chemistry and physics or biology; and if a graduate of an approved college of podiatry or podiatric medicine subsequent to July 1, 1971, that he or she has completed a course of study of two such prepodiatry college years, including the study of chemistry, physics or mathematics and biology, and that he or she received the degree of D.P.M., Doctor of Podiatric Medicine. No provision of this section shall be construed to prevent graduates of a podiatric college, approved by the Board of Examiners in Podiatry with the consent of the Commissioner of Public Health, from receiving practical training in podiatry in a residency program in an accredited hospital facility which program is accredited by the Council on Podiatric Education.

Sec. 27. Subsection (a) of section 20-71 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Department of Public Health may issue a license to practice physical therapy without examination, on payment of a fee of two hundred twenty-five dollars, to an applicant who is a physical therapist registered or licensed under the laws of any other state or territory of the United States, any province of Canada or any other country, if the requirements for registration or licensure of physical therapists in such state, territory, province or country **[**were, at the time of application, similar to**]** are deemed by the department to be equivalent to, or higher than **[**the requirements in force in this state**]** those prescribed in this chapter.

Sec. 28. Subsection (b) of section 20-71 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(b) The department may issue a physical therapist assistant license without examination, on payment of a fee of one hundred fifty dollars, to an applicant who is a physical therapist assistant registered or licensed under the laws of any other state or territory of the United States, any province of Canada or any other country, if the requirements for registration or licensure of physical therapist assistants in such state, territory, province or country **[**were, at the time of application, similar to**]** are deemed by the department to be equivalent to, or higher than **[**the requirements in force in this state**]** those prescribed in this chapter.

Sec. 29. Subsection (b) of section 20-73d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(b) Each insurance company **[**which**]** that issues professional liability insurance, as defined in subdivision (10) of subsection (b) of section 38a-393, shall on and after January 1, 2007, render to the

Commissioner of Public Health a true record of the names and addresses, according to classification, of cancellations of and refusals to renew professional liability insurance policies and the reasons for such **[**cancellation or refusal**]** cancellations or refusals to renew said policies for the year ending on the thirty-first day of December next preceding.

Sec. 30. Subsection (b) of section 20-126d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(b) Each insurance company that issues professional liability insurance, as defined in subdivision (4) of subsection (b) of section 38a-393, shall on and after January 1, 2007, render to the Commissioner of Public Health a true record of the names and addresses, according to classification, of cancellations of and refusals to renew professional liability insurance policies and the reasons for such **[**cancellation or refusal**]** cancellations or refusals to renew said policies for the year ending on the thirty-first day of December next preceding.

Sec. 31. Section 20-130 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

Each person, before beginning the practice of optometry in this state, except as hereinafter provided, shall present to the Department of Public Health satisfactory evidence that **[**he has a qualifying academic certificate from the Commissioner of Education showing that he has been graduated after a four years' course of study in a public high school approved by the State Board of Education, or has a preliminary education equivalent thereto, and**]** such person has been graduated from a school of optometry approved by the board of examiners with the consent of the Commissioner of Public Health. **[**and maintaining a course of study of not less than four years.**]** The board shall consult, where possible, with nationally recognized accrediting agencies when approving schools of optometry. **[**No school of optometry shall be approved unless it has a minimum requirement of a course of study of one thousand attendance hours. No school shall be disapproved by the board solely because it is located in a country

other than the United States or its territories or possessions. The qualifications of any applicant who has not been graduated from an approved public high school shall be determined by the State Board of Education by adequate preliminary examination, the fee for which shall be twenty-five dollars.**]** All applicants shall be required to **[**take**]** successfully complete an examination **[**conducted**]** prescribed by the Department of Public Health **[**under the supervision**]** with the consent of the board of examiners, in theoretic, practical and physiological optics, theoretic and practical optometry, ocular pharmacology and the anatomy and physiology of the eye; and said department shall determine the qualifications of the applicant and, if they are found satisfactory, shall give a license to that effect. Passing scores shall be established by the department with the consent of the board. The department may, upon receipt of four hundred fifty dollars, **[**accept and approve, in lieu of the examination required in this section, a diploma of the National Board of Examiners in Optometry, subject to the same conditions as hereinafter set forth for acceptance, in lieu of examination, of a license from a board of examiners in optometry of any state or territory of the United States or the District of Columbia and may issue to such person a statement certifying to the fact that such person has been found qualified to practice optometry. Any**]** issue a license to any person who is a currently practicing competent practitioner who **[**presents to the Department of Public Health a certified copy or certificate of registration or license, which was**]** holds a license issued to **[**him**]** such person after examination by a board of registration in optometry in any other state or territory of the United States in which the requirements for registration are deemed by the department to be equivalent to, or higher than, those prescribed in this chapter. **[**, may be given a license without examination, provided such state shall accord a like privilege to holders of licenses issued by this state. The fee for such license shall be four hundred fifty dollars. The times and places of examination of applicants shall be determined by the department. Each applicant shall pay to the department the sum of fifty dollars before examination. No person otherwise qualified under the provisions of this section shall be denied the right to apply for or

receive an optometrist's license solely because he is not a citizen of the United States.**]** No license shall be issued **[**without examination**]** under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. **[**The department shall inform the board annually of the number of applications it receives for licensure without examination under this section.**]**

Sec. 32. Subsection (b) of section 20-162r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(b) Except as otherwise provided in this section, for registration periods beginning on and after October 1, 2007, a licensee applying for license renewal shall **[**either maintain credentialing as a respiratory therapist, issued by the National Board for Respiratory Care, or its successor organization, or**]** earn a minimum of six hours of continuing education within the preceding registration period. Such continuing education shall (1) be directly related to respiratory therapy; and (2) reflect the professional needs of the licensee in order to meet the health care needs of the public. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Association for Respiratory Care, regionally accredited institutions of higher education, or a state or local health department.

Sec. 33. Subsection (g) of section 20-222 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(g) Any person, firm, partnership or corporation engaged in the funeral service business shall maintain at the address of record of the funeral service business identified on the certificate of inspection:

(1) All records relating to contracts for funeral services, prepaid funeral contracts or escrow accounts shall, **[**be maintained at the address of record of the funeral home identified on the certificate of

inspection**]** for a period of not less than three years after the death of the individual for whom funeral services were provided;

(2) Copies of all death certificates, burial permits, authorizations for cremation, documentation of receipt of cremated remains and written agreements used in making arrangements for final disposition of dead human bodies, including, but not limited to, copies of the final bill and other written evidence of agreement or obligation furnished to consumers, for a period of not less than three years after such final disposition; and

(3) Copies of price lists, for a period of not less than three years from the last date such lists were distributed to consumers.

Sec. 34. Section 20-363 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The commissioner may refuse to issue or renew or may suspend or revoke a license or take any of the actions set forth in section 19a-17 upon proof that the applicant or license holder (1) has employed or knowingly cooperated in fraud or material deception in order to obtain **[**his**]** a license or has engaged in fraud or material deception in the course of professional services or activities at any place; (2) has been guilty of illegal, incompetent or negligent conduct in his or her practice; **[**or**]** (3) has violated any provision of this chapter or any regulation adopted **[**hereunder**]** under this chapter; (4) has been found guilty or convicted as a result of an act which constitutes a felony under (A) the laws of this state, (B) federal law, or (C) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state; or (5) has been subject to disciplinary action similar to that specified in section 19a-17 by a duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction. The commissioner may petition the superior court for the judicial district of Hartford to enforce any action taken pursuant to section 19a-17. Before the commissioner may suspend, revoke or refuse to renew a license or take such other action, **[**he**]** the

commissioner shall give the applicant or license holder notice and opportunity for hearing as provided in the regulations adopted by the commissioner.

Sec. 35. Section 20-54 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) No person other than those described in section 20-57 and those to whom a license has been reissued as provided by section 20-59 shall engage in the practice of podiatry in this state until such person has presented to the department satisfactory evidence that such person has had a high school education or its equivalent, has received a diploma or other certificate of graduation from an accredited school or college of chiropody or podiatry approved by the Board of Examiners in Podiatry with the consent of the Commissioner of Public Health nor shall any person so practice until such person has obtained a license from the Department of Public Health after meeting the requirements of this chapter. A graduate of an approved school of chiropody or podiatry subsequent to July 1, 1947, shall present satisfactory evidence that he or she has been a resident student through not less than four graded courses of not less than thirty-two weeks each in such approved school and has received the degree of D.S.C., Doctor of Surgical Chiropody, or Pod. D., Doctor of Podiatry, or other equivalent degree; and, if a graduate of an approved chiropody or podiatry school subsequent to July 1, 1951, that he or she has completed, before beginning the study of podiatry, a course of study of an academic year of not less than thirty-two weeks' duration in a college or scientific school approved by said board with the consent of the Commissioner of Public Health, which course included the study of chemistry and physics or biology; and if a graduate of an approved college of podiatry or podiatric medicine subsequent to July 1, 1971, that he or she has completed a course of study of two such prepodiatry college years, including the study of chemistry, physics or mathematics and biology, and that he or she received the degree of D.P.M., Doctor of Podiatric Medicine. No provision of this section shall be construed to prevent graduates of a podiatric college, approved by the Board of

Examiners in Podiatry with the consent of the Commissioner of Public Health, from receiving practical training in podiatry in a residency program in an accredited hospital facility which program is accredited by the Council on Podiatric Education.

(b) A licensed podiatrist who is board qualified or certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine may engage in the medical and nonsurgical treatment of the ankle and the anatomical structures of the ankle, as well as the administration and prescription of drugs incidental thereto, and the nonsurgical treatment of manifestations of systemic diseases as they appear on the ankle. Such licensed podiatrist shall restrict treatment of displaced ankle fractures to the initial diagnosis and the initial attempt at closed reduction at the time of presentation and shall not treat tibial pilon fractures. For purposes of this **[**subsection**]** section, "ankle" means the distal metaphysis and epiphysis of the tibia and fibula, the articular cartilage of the distal tibia and distal fibula, the ligaments that connect the distal metaphysis and epiphysis of the tibia and fibula and the talus, and the portions of skin, subcutaneous tissue, fascia, muscles, tendons and nerves at or below the level of the myotendinous junction of the triceps surae.

(c) No licensed podiatrist may independently engage in the surgical treatment of the ankle, including the surgical treatment of the anatomical structures of the ankle, as well as the administration and prescription of drugs incidental thereto, and the surgical treatment of manifestations of systemic diseases as they appear on the ankle, until such licensed podiatrist has obtained a permit from the Department of Public Health after meeting the requirements set forth in subsection (d) or (e) of this section, as appropriate. No licensed podiatrist who applies for a permit to independently engage in the surgical treatment of the ankle shall be issued such permit unless (1) the commissioner is satisfied that the applicant is in compliance with all requirements set forth in subsection (d) or (e) of this section, as appropriate, and (2) the application includes payment of a fee in the amount of one hundred

dollars. For purposes of this section, "surgical treatment of the ankle" does not include the performance of total ankle replacements or the treatment of tibial pilon fractures.

(d) The Department of Public Health may issue a permit to independently engage in standard ankle surgery procedures to any licensed podiatrist who: (1) (A) Graduated on or after June 1, 2006, from a three-year residency program in podiatric medicine and surgery that was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, and (B) holds and maintains current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization; (2) (A) graduated on or after June 1, 2006, from a three-year residency program in podiatric medicine and surgery that was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, (B) is board qualified, but not board certified, in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in standard or advanced midfoot, rearfoot and ankle procedures; or (3) (A) graduated before June 1, 2006, from a residency program in podiatric medicine and surgery that was at least two-years in length and was accredited by the Council on Podiatric Medical Education at the time of graduation, (B) holds and maintains current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in standard or advanced midfoot, rearfoot and ankle procedures; except that a licensed podiatrist who meets the qualifications of subdivision (2) of this subsection may not perform tibial and fibular osteotomies until such licensed podiatrist holds and maintains current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Medicine, or its successor organization. For purposes of this subsection, "standard ankle surgery

procedures" includes soft tissue and osseous procedures.

(e) The Department of Public Health may issue a permit to independently engage in advanced ankle surgery procedures to any licensed podiatrist who has obtained a permit under subsection (d) of this section, or who meets the qualifications necessary to obtain a permit under said subsection (d), provided such licensed podiatrist: (1) (A) Graduated on or after June 1, 2006, from a three-year residency program in podiatric medicine and surgery that was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, (B) holds and maintains current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in advanced midfoot, rearfoot and ankle procedures; or (2) (A) graduated before June 1, 2006, from a residency program in podiatric medicine and surgery that was at least two-years in duration and was accredited by the Council on Podiatric Medical Education at the time of graduation, (B) holds and maintains current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in advanced midfoot, rearfoot and ankle procedures. For purposes of this subsection, "advanced ankle surgery procedures" includes ankle fracture fixation, ankle fusion, ankle arthroscopy, insertion or removal of external fixation pins into or from the tibial diaphysis at or below the level of the myotendinous junction of the triceps surae, and insertion and removal of retrograde tibiotalocalcaneal intramedullary rods and locking screws up to the level of the myotendinous junction of the triceps surae, but does not include the surgical treatment of complications within the tibial diaphysis related to the use of such external fixation pins.

(f) A licensed podiatrist who (1) graduated from a residency

program in podiatric medicine and surgery that was at least two years in duration and was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, and (2) (A) holds and maintains current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization, (B) is board qualified in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor organization, or (C) is board certified in foot and ankle surgery by the American Board of Podiatric Surgery, or its successor organization, may engage in the surgical treatment of the ankle, including standard and advanced ankle surgery procedures, without a permit issued by the department in accordance with subsection (d) or (e) of this section, provided such licensed podiatrist is performing such procedures under the direct supervision of a physician or surgeon licensed under chapter 370 who maintains hospital privileges to perform such procedures or under the direct supervision of a licensed podiatrist who has been issued a permit under the provisions of subsection (d) or (e) of this section, as appropriate, to independently engage in standard or advanced ankle surgery procedures.

(g) The Commissioner of Public Health shall appoint an advisory committee to assist and advise the commissioner in evaluating applicants' training and experience in midfoot, rearfoot and ankle procedures for purposes of determining whether such applicants should be permitted to independently engage in standard or advanced ankle surgery procedures pursuant to subsection (d) or (e) of this section. The advisory committee shall consist of four members, two of whom shall be podiatrists recommended by the Connecticut Podiatric Medical Association and two of whom shall be orthopedic surgeons recommended by the Connecticut Orthopedic Society.

(h) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to implement the provisions of subsections (c) to (f), inclusive, of this section. Such regulations shall include, but not be limited to, the number and types of procedures

required for an applicant's training or experience to be deemed acceptable for purposes of issuing a permit under subsection (d) or (e) of this section. In identifying the required number and types of procedures, the commissioner shall seek the advice and assistance of the advisory committee appointed under subsection (g) of this section and shall consider nationally recognized standards for accredited residency programs in podiatric medicine and surgery for midfoot, rearfoot and ankle procedures.

(i) The Department of Public Health's issuance of a permit to a licensed podiatrist to independently engage in the surgical treatment of the ankle shall not be construed to obligate a hospital or outpatient surgical facility to grant such licensed podiatrist privileges to perform such procedures at the hospital or outpatient surgical facility.

Sec. 36. Section 20-59 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The board may take any of the actions set forth in section 19a-17, as amended by this act, for any of the following reasons: (1) Procurement of a license by fraud or material deception; (2) conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of podiatry; (3) fraudulent or deceptive conduct in the course of professional services or activities; (4) illegal or incompetent or negligent conduct in the practice of podiatry; (5) habitual intemperance in the use of spirituous stimulants or addiction to the use of morphine, cocaine or other drugs having a similar effect; (6) aiding and abetting the practice of podiatry by an unlicensed person or a person whose license has been suspended or revoked; (7) mental illness or deficiency of the practitioner; (8) physical illness or loss of motor skill, including but not limited to, deterioration through the aging process, of the practitioner; (9) undertaking or engaging in any medical practice beyond the privileges and rights accorded to the practitioner of podiatry by the provisions of this chapter; (10) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in subsection (a) of

section 20-58a; (11) independently engaging in the performance of ankle surgery procedures without a permit, in violation of section 20-54, as amended by this act; or **[**(11)**]** (12) violation of any provision of this chapter or any regulation adopted hereunder. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17, as amended by this act. The clerk of any court in this state in which a person practicing podiatry has been convicted of any crime shall, upon such conviction, make written report, in duplicate, to the Department of Public Health of the name and residence of such person, the crime of which such person was convicted and the date of conviction; and said department shall forward one of such duplicate reports to the board.

Sec. 37. Section 19a-116a of the general statutes is repealed. (*Effective October 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2007*	1-43
Sec. 2	*October 1, 2007*	1-55
Sec. 3	*October 1, 2007*	17a-238(g)
Sec. 4	*October 1, 2007*	19a-7d(a)
Sec. 5	*October 1, 2007*	19a-17(a)
Sec. 6	*October 1, 2007*	19a-26
Sec. 7	*October 1, 2007*	19a-121
Sec. 8	*October 1, 2007*	19a-121c
Sec. 9	*October 1, 2007*	19a-121f
Sec. 10	*October 1, 2007*	19a-180(i)
Sec. 11	*October 1, 2007*	19a-322
Sec. 12	*October 1, 2007*	19a-490(a)
Sec. 13	*October 1, 2007*	19a-490(l)
Sec. 14	*October 1, 2007*	19a-561(c)(3)
Sec. 15	*October 1, 2007*	19a-562(a)
Sec. 16	*October 1, 2007*	19a-562(c)
Sec. 17	*October 1, 2007*	19a-562a

Sec. 18	*October 1, 2007*	19a-570
Sec. 19	*October 1, 2007*	19a-575a
Sec. 20	*October 1, 2007*	19a-577
Sec. 21	*October 1, 2007*	19a-580f
Sec. 22	*October 1, 2007*	20-8a(c)
Sec. 23	*from passage*	20-12a(7)
Sec. 24	*from passage*	20-74s(a)(7)
Sec. 25	*from passage*	20-74s(t)
Sec. 26	*October 1, 2007*	20-54(a)
Sec. 27	*October 1, 2007*	20-71(a)
Sec. 28	*October 1, 2007*	20-71(b)
Sec. 29	*October 1, 2007*	20-73d(b)
Sec. 30	*October 1, 2007*	20-126d(b)
Sec. 31	*October 1, 2007*	20-130
Sec. 32	*October 1, 2007*	20-162r(b)
Sec. 33	*October 1, 2007*	20-222(g)
Sec. 34	*October 1, 2007*	20-363
Sec. 35	*October 1, 2007*	20-54
Sec. 36	*October 1, 2007*	20-59
Sec. 37	*October 1, 2007*	Repealer section

JUD *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 $	FY 09 $
Public Health, Dept.	GF - Revenue Impact	Potential Minimal	Potential Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

Sections 1, 2, and 18-21 make technical changes to and otherwise update Connecticut law on health care decision making. Changes within these sections do not result in a fiscal impact.

Sections 3, 4, 7-10, 12-17, and 22-31 make technical changes, repeal obsolete statutory references, clarify or otherwise align statute with current practice. No fiscal impact is associated with changes contained within these sections.

Section 5 increases from $10,000 to $25,000 the maximum civil penalty that may be assessed in the course of disciplinary proceedings involving health care professionals. To the extent that such penalties are assessed, a potential minimal revenue gain may result. In the last three years (2003 – 2006), the number of penalties assessed at the $10,000 maximum has ranged from two to five a year.

Section 6 eliminates a requirement of current law that the Department of Public Health establish a schedule of laboratory fees (for analytical work performed by the Connecticut State Laboratory) based upon national recognized standards and performance measures. No fiscal impact is anticipated to result. The department does not intend to modify laboratory fees in response to enactment of this bill. Other changes in this section are technical in nature and have no

associated fiscal impact.

Section 11 sets forth a minimum time period for crematories to maintain certain records and results in no fiscal impact.

Section 23 removes a requirement of current law that a designated alternate supervising physician register with the DPH. As a $37.50 fee is paid to the department by registrants, a potential minimal revenue loss is associated with this change. Aggregate payments by supervising physicians average about $6,000 a year – a small portion of this amount is attributable to alternate supervising physicians.

Section 32 modifies requirements that must be met by a respiratory therapist at the time of his or her license renewal. No fiscal impact is associated with the changes contained within this section.

Section 33 sets forth a minimum time period for funeral service businesses to maintain certain records and results in no fiscal impact.

Section 34 may facilitate the denial or revocation of a license to a registered sanitarian having been found guilty of a felony, or having been disciplined by non-Connecticut regulatory body. A potential minimal revenue loss to the state would ensue. Registered Sanitarians pay an initial fee of $40 and a renewal fee of $20.

An estimated fifteen podiatrists will pay a $100 fee in FY 08 to obtain a permit to engage in surgical treatment of the ankle, given passage of **Sections 35 and 36.** A potential minimal revenue gain in future fiscal years will result to the extent that additional podiatrists apply for a permit.

These sections make the performance of ankle surgery by a podiatrist without the requisite permit a cause for disciplinary action by the Board of Examiners in Podiatry. A potential minimal revenue gain to the state will result, should a civil penalty of up to $10,000 be assessed against any person found in violation of this provision. The Department of Public Health will be able to perform duties stated in Sections 35 and 36 within its normally budgeted resources.

Section 37 repeals a requirement that clinical practices performing infertility treatments report certain information to the DPH. No fiscal impact is associated with this change.

The Out Years

State Impact:

Agency Affected	Fund-Effect	FY 10 $	FY 11 $	FY 12 $
Public Health, Dept.	GF - Revenue Impact	Potential Minimal	Potential Minimal	Potential Minimal

Note: GF=General Fund

Municipal Impact: None

OLR Bill Analysis

sHB 7163

AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES AND REVISING THE SCOPE OF PODIATRIC MEDICINE.

SUMMARY:

This bill expands the scope of practice of podiatric medicine to allow podiatrists to engage independently in standard and advanced ankle surgery procedures if they meet certain requirements and qualifications. Under the bill, licensed podiatrists with additional qualifications beyond board qualification or certification may be permitted to perform surgical treatment of the ankle. Surgical treatment of the ankle does not include the performance of total ankle replacements or treatment of tibial pilon fractures.

Under the bill, a podiatrist cannot engage in independent ankle surgery procedures without receiving a permit from the Department of Public Health (DPH). DPH must develop a process for issuing such permits.

The bill requires the DPH commissioner to appoint a four- member advisory committee consisting of podiatrists and orthopedists to assist in evaluating permit applicants. The commissioner must also adopt regulations concerning the evaluation of an applicant's training and experience in various ankle procedures.

This bill also makes numerous substantive and technical changes to Department of Public Health (DPH) and other related statutes concerning health care professionals, health care facilities, programs and activities, as well as health care decision making.

EFFECTIVE DATE: October 1, 2007, except for the provisions on

physician assistant supervision registration and alcohol and drug counselors which take effect upon passage.

§ 35 — STANDARD AND ADVANCED ANKLE SURGERY PROCEDURES

Under the bill, "standard ankle surgery procedures" include soft tissue and osseous (bone) procedures.

"Advanced ankle surgery procedures" include ankle fracture fixation, ankle fusion, ankle arthroscopy, insertion or removal of external fixation pins into or from the tibial diaphysis (shaft of a long bone) at or below the level of the myotendinous junction (junction formed by the skeletal muscles where they adhere to tendons) of the triceps surae, and insertion and removal of retrograde tibiotalocalcaneal intramedullary rods and locking screw up to the level of the myotendinous junction of the triceps surae. It does not include the surgical treatment of complications within the tibial diaphysis related to the use of such external fixation pins.

"Triceps surae" refers to the group of lower leg muscles called the gastrocnemius and the soleus. The gastrocnemius is the two-headed, heart-shaped muscle in the back of the lower leg. The soleus is the broader, flat muscle just beneath the gastrocs. Both of these muscles attach to the heal bone via the Achilles tendon. The triceps surae makes up the superficial, posterior lower leg compartment.

Independent Ankle Surgery

Requirements for Standard Ankle Surgery. The bill permits licensed podiatrists with the following qualifications to independently engage in standard ankle procedures:

1. those who graduated on or after June 1, 2006 from a three-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education, or its successor, at the time of graduation and hold and maintain current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor;

2. those who graduated on or after June 1, 2006 from a three-year residency program in podiatric medicine and surgery accredited by the council or its successor, at the time of graduation, who are qualified, but not certified, in reconstructive rearfoot ankle surgery by the board or its successor, and provides documentation satisfactory to DPH of their training and experience in standard or advanced midfoot, rearfoot, and ankle procedures, except that such applicants cannot perform osteotomies of the tibia and fibula until they hold and maintain current board certification as described above; or

3. those who graduated before June 1, 2006 from a residency program in podiatric medicine and surgery of at least two years that was accredited by the council at the time of graduation, hold and maintain current board certification, and provide satisfactory documentation to DPH of their training and experience in standard or advanced midfoot, rearfoot, and ankle procedures.

Requirements for Advanced Ankle Surgery. Under the bill, licensed podiatrists with the following qualifications can engage independently in advanced ankle surgery procedures:

1. those who graduated on or after June 1, 2006 from a three-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education or its successor, at the time of graduation, hold and maintain current board certification in Reconstructive Rear foot/Ankle Surgery by the American Board of Podiatric Surgery or its successor, and provide satisfactory documentation to DPH of their training and experience in advanced midfoot, rearfoot, and ankle procedures; or

2. those who graduated before June 1, 2006 from a residency program in podiatric medicine and surgery of at least two years and accredited by the council at the time of graduation, hold and maintain current board certification, and provide satisfactory

documentation to DPH of their training and experience in advanced midfoot, rearfoot, and ankle procedures.

Ankle Surgery Under The Direct Supervision of a Physician or Surgeon

The bill allows a licensed podiatrist who has the following qualifications to surgically treat the ankle, including using standard and advanced podiatric ankle surgery procedures, without a permit until the podiatrist meets the requirements for a permit for independent ankle surgery. In this situation, the podiatrist must perform these procedures under the direct supervision of a licensed physician or surgeon who has hospital privileges in the procedure or of a licensed podiatrist who has a permit for independent ankle surgery. The podiatrist must:

1. have graduated from a minimum two-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education, or its successor, at the time of graduation; and

2. hold and maintain current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery or its successor, is board qualified in such surgery by the board or its successor, or is currently board certified in foot and ankle surgery by the board or its successor.

DPH Permit Process

The bill requires DPH to establish a process to issue permits to qualified licensed podiatrists to independently perform standard or advanced ankle surgery procedures as described above. No licensed podiatrist may independently engage in the surgical treatment of the ankle or the anatomical structures of the ankle, administer or prescribe drugs incidental to such treatment, or surgically treat manifestations of systemic diseases as they appear on the ankle, until the podiatrist has obtained a DPH permit.

DPH cannot issue a permit unless the applicant meets all of the

requirements for independent ankle surgery as described above and pays a $100 fee.

The bill specifies that "surgical treatment of the ankle" does not include the performance of total ankle replacements or the treatment of tibial pilon fractures.

Advisory Committee

The bill requires the DPH commissioner to appoint a four-member advisory committee to assist and advise him in evaluating an applicant's training and experience in midfoot, rearfoot, and ankle procedures required for permit eligibility. Two committee members must be podiatrists recommended by the Connecticut Podiatric Medical Association and two must be orthopedists recommended by the Connecticut Orthopedic Society.

Regulations

The bill requires DPH to adopt regulations on the permit issuance process, including evaluation of an applicant's training and experience in the procedures required for a permit. The regulations must include the number and types of procedures required for an applicant to demonstrate training or experience in standard and advanced ankle procedures. DPH must seek the advisory committee's advice and assistance and consider nationally recognized standards for accredited residency programs in podiatric medicine and surgery in developing the regulations.

Podiatrist Privileges

The bill specifies that DPH's permit issuance to a licensed podiatrist to independently engage in ankle surgery does not obligate a hospital or outpatient surgical facility to grant privileges to that podiatrist.

§ 36 — DISCIPLINARY ACTION AGAINST PODIATRISTS

The bill adds engaging in surgical treatment of the ankle without the required permit to those grounds on which the Connecticut Board of Examiners in Podiatry can take disciplinary action against a

podiatrist.

§ 5 — CIVIL PENALTIES AGAINST HEALTH CARE PROFESSIONALS

The bill increases, from $10,000 to $25,000, the amount of a civil penalty DPH and various health professional regulatory boards can assess a health care professional. Under the law, DPH and various health professional boards and commissions can, after a finding of good cause, take various disciplinary actions against licensed health professionals. These actions include license suspension or revocation, censure, letter of reprimand, probation, or assessment of a civil penalty.

§ 6 — LABORATORY FEES

The bill allows, rather than requires, the DPH commissioner to set laboratory fees and to do so without basing them on nationally recognized standards and performance measures for analytic work effort for such services as currently required. By law, DPH can establish state laboratories to test for preventable disease, as well as perform sanitation, environmental, and occupational testing.

Laboratory services are done without charge for local health directors and local law enforcement officials. The law also allows for partial, as well as full, fee waivers for others if the commissioner determines the public health requires it. The bill clarifies that the commissioner can waive the fees if he establishes a fee schedule.

§§ 7-9 — HIV AND AIDS SERVICES

The bill revises funding provisions for HIV and AIDS services. It expands the type of organizations that can receive funds to provide such services and expands service recipients to include people with HIV and those at risk of contracting HIV or AIDS.

Under current law, DPH must establish a grant program to provide funds to private agencies that provide services to persons suffering from AIDS and their families. Under the bill, qualifying individuals and organizations, including local health departments, that serve

people infected with, at risk of, and affected by HIV or AIDS are eligible for grants.

Currently, agencies receiving DPH funding to provide AIDS tests must give priority to persons in high risk categories and must establish a fee schedule based on ability to pay. The bill eliminates the fee schedule requirement and specifies that the testing is for HIV.

The bill also specifies that DPH's existing public information program must address HIV as well as AIDS.

The bill broadens the eligibility criteria for grant-in-aid applicants for programs to study or treat AIDS. Under the bill, such grants are available to qualifying individuals or organizations instead of just any hospital, municipality, public independent college or university, or individual. It also provides that the grants are for studying or treating HIV, AIDS, or both.

§ 11 — CREMATORIES

The bill requires crematories to keep on their premises records, copies of cremation permits, cremation authorization documentation, and documentation of receipt of cremated remains for at least three years after final disposition of the cremated remains.

§ 33 — FUNERAL SERVICE BUSINESSES

The bill requires a person, firm, partnership, or corporation involved in the funeral service business to keep at the funeral business address of record (1) copies of all death certificates, burial permits, cremation authorizations, receipts for cremated remains, and written agreements used in making arrangements for final disposition of dead bodies, including copies of the final bill and other written evidence of agreement or obligation given to consumers, for at least three years after final disposition and (2) copies of price lists, for at least three years from the last date they were distributed to consumers.

§§ 12 & 13 — ASSISTED LIVING SERVICES AGENCY

The bill adds assisted living services agencies to the statutory list of

health care institutions and makes a technical change to the definition of such agencies.

§§ 1, 2, & 21 — APPOINTMENT OF HEALTH CARE AGENT, POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

The bill specifies that a short form power of attorney no longer can be used for health care decision purposes.

The bill specifies that an appointment of a (1) health care agent or (2) power of attorney for health care decisions, properly executed before October 1, 2006 under the law in effect at that time has the same legal force and effect as if it had been executed according to the law after October 1, 2006. PA 06-195 amended and updated Connecticut law on health care decision making by, among other things, (1) combining the authority of the health care agent and attorney-in-fact for health care decisions into a unified proxy known as the "health care representative" and (2) authorizing the health care representative to make any and all health care decisions for a person incapable of expressing those wishes.

§ 23 — PHYSICIAN ASSISTANTS-ALTERNATE SUPERVISING PHYSICIAN

By law, each physician assistant (PA) must have a clearly identified supervising physician, registered with DPH. A designated alternative physician to supervise in the absence of the supervising physician also must be registered with DPH. The bill eliminates the requirement of registering the alternate supervising physician.

§§ 24 & 25 — ALCOHOL AND DRUG COUNSELORS

Current law provides that the alcohol and drug abuse counselor licensure and certification statutes do not apply to the activities of various licensed professionals acting within the scope of their profession, doing work consistent with their training, and not holding themselves out as alcohol and drug counselors.

The bill amends this exception by (1) removing chiropractors, acupuncturists, physical therapists, and occupational therapists from

the exempt list; (2) adding professional counselors; and (3) specifying that nurses mean advanced practice registered nurses and registered nurses. It also specifies that the person must be working consistent with his or her license, rather than "training."

§ 26 — PODIATRY

The bill eliminates a requirement that a podiatrist provide DPH with satisfactory evidence of a high school diploma or its equivalent in order to obtain a license.

§§ 27 & 28 — PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

The law allows DPH to license without examination physical therapists and physical therapist assistants licensed or registered in another state or nation with similar or higher requirements than Connecticut's. The bill instead specifies that the other state's or nation's requirements must be deemed by DPH to be equivalent to or higher than Connecticut's.

§ 31 — OPTOMETRISTS

The bill deletes (1) requirements that an optometrist applying for a license present satisfactory evidence to DPH of graduating from an approved high school or its equivalent and (2) related provisions and examination fees concerning license applicants who have not graduated from an approved high school. It deletes a requirement that optometry schools have a minimum course of study of 1,000 attendance hours in order to be approved by the state optometry board. It also eliminates a provision that specifies that a school cannot be disapproved solely because it is located outside of the United States.

The bill requires that optometric license applicants successfully complete an examination prescribed, rather than conducted, by DPH with the consent of (instead of under the supervision of) the Board of Examiners for Optometrists.

The bill makes both technical and substantive changes to requirements for licensure by endorsement. (Endorsement basically

means that a licensee from another state may be eligible for licensure, without examination, in this state provided that the applicant has credentials and qualifications substantially equivalent to Connecticut's licensure requirements.) The bill eliminates a requirement that the other state give a similar privilege to Connecticut licensees seeking licensure in that state in order for Connecticut to license someone from that state by endorsement. It also eliminates (1) a requirement that DPH annually inform the optometry board of the number of applications it receives for licensure without examination and (2) a provision that specifies that an otherwise qualified person cannot be denied the right to apply for or receive an optometrist's license solely because he is not a United States citizen. It also eliminates a $50 examination fee.

§ 32 — RESPIRATORY CARE PRACTITIONERS

This law requires a respiratory care practitioner applying for license renewal to either (1) earn a minimum of six contact hours of continuing education within the preceding registration period or (2) maintain credentialing as a respiratory therapist from the National Board for Respiratory Care. The bill eliminates the latter option. A registration period is the one-year period for which a renewed license is current and valid.

§ 34 — SANITARIANS

The bill expands the grounds on which DPH may refuse to issue or renew, or suspend, a license or take other disciplinary action against a sanitarian as follows: (1) the sanitarian has been found guilty or convicted of an act which is a felony under Connecticut or federal law, or under the laws of another jurisdiction, which, if committed in Connecticut, would have been a felony or (2) the sanitarian has been subject to disciplinary action similar to that of Connecticut's by an authorized professional disciplinary agency in any state, the District of Columbia, a U.S. territory or possession, or a foreign country.

§ 37— IN-VITRO FERTILIZATION REPORTS

The bill eliminates a requirement that a clinical practice performing

in-vitro fertilization, gamete intra-fallopian transfer, or zygote intra-fallopian transfer procedures covered by insurance report certain information to DPH.

BACKGROUND

Legislative History

The House referred the bill (File 431) to the Judiciary Committee on April 17. That committee favorably reported a substitute bill that merged the language of HB 6700 (File 159) on the scope of podiatric medicine into this bill.

Related Bills

sHB 7160 concerns funeral service businesses and crematories; sSB 7089 eliminates the registration requirement and corresponding fee for physicians supervising physician assistants; HB 6700 expands the scope of practice of podiatrists; sHB 7159 changes the scope of practice of optometrists; sHB 7157 addresses staff training requirements for Alzheimer's Special Care Units (§§ 15 to 17 of sHB 7163 make technical changes, concerning Alzheimer's special care units); and SB 1144 establishes a central index for advanced heath care directives.

PA 06-160

PA 06-160 required the DPH commissioner to convene a panel, directed by an arbitrator, to develop a protocol and recommendations for allowing qualified podiatrists to perform surgery on the ankle. DPH issued its findings and recommendations in a January 2007 report.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 27 Nay 0 (03/21/2007)

Judiciary Committee

Joint Favorable Substitute
Yea 39 Nay 0 (04/23/2007)